



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

SOUTHWEST GENERAL HOSPITAL  
1415 LOUISIANA SUITE 2225  
HOUSTON TX 77002

#### **Respondent Name**

TEXAS MUNICIPAL LEAGUE

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-07-4961-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "The above referenced patient received outpatient surgical care at Southwest General Hospital. Since the hospital is not an Ambulatory Surgical Center and does not have a separate ASC unit, according to Rule §134.401 Acute Care Inpatient Hospital Fee Guideline, this claim should have been 'reimbursed at a fair and reasonable rate.' Apparently the Payor improperly applied the ASC Fee Guideline or utilized some other non-applicable fee schedule to significantly underpay this claim. This patient was employed and covered under their company sponsored WC insurance plan. The patient's WC group plan is much more comparable to an employer sponsored health plan than a government sponsored individual policy such as Medicare and Medicaid with typically cover the unemployed. It is neither 'fair' nor 'reasonable' for the payor to apply a non-applicable Medicare fee schedule to this claim. It would be significantly more 'fair and reasonable' for the Hospital to be reimbursed based on the average commercial (non-governmental) managed care contract reimbursement rate. An audit of all the Hospital's non-governmental managed care contract reimbursement rates has confirmed the average reimbursement for this same outpatient surgical procedure is 65% of the Hospital's billed charges. Based on compliance with Rule §134.401 and an impartial and just 'fair and reasonable' allowance, the Hospital should be aid nothing less than 65% for this claim. "

**Amount in Dispute:** \$9,591.42

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "Self-insured has previously responded to this dispute on 05/02/2007. Carrier hand not applied any PPO/voluntary-informal network contract rates in calculating the reimbursements in this case. Self-insured's calculation of the fair and reasonable reimbursement rate for this outpatient surgical charge was based upon twice the inpatient surgical reimbursement rate (\$1118 x 2 - \$2236). Additional reimbursements of \$183.47 and \$127.50 were issued for supplies and implants. Self-insured is unaware of any applicable PPO/voluntary-informal network contact."

**Response Submitted by:** Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

## SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2006	Outpatient Surgery	\$9,591.42	\$0.00

## FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on April 5, 2007.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 510 – Payment Determined.
  - W10 – Payment – fair and reasonable methodology/
  - 304 – Submit Supply House Invoice for additional
  - 45 – Charges >contracted/legislated fee arrang
  - 68 – No additional allowance recommended
  - V4 – No additional payment allowed after review.

### Findings

1. Claim adjustment code 45 noted, that the reason for reduction was due to "Charges > your contracted/legislated fee arrang." The Respondent, in their position summary, stated that the Carrier had not applied any PPO/voluntary-information network contract rates. Therefore, the services in dispute will be reviewed per applicable Division rules and fee guidelines
2. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(A), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all medical bill(s)... as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration..." Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A).
5. 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "a description of the health care for which payment is in dispute." Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).

6. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
- The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:  
“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”  
Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
  - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
  - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
  - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
February 14, 2012  
Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**